Increasing Food Access for High-Risk Patients in South LA

St. John's Well Child & Family Center

Monica Cotom, Elena Fernandez, Roberto Rodarte, Kazumi Yamaguchi, Sharine Forbes

St. John's Internal Use, External Stakeholders

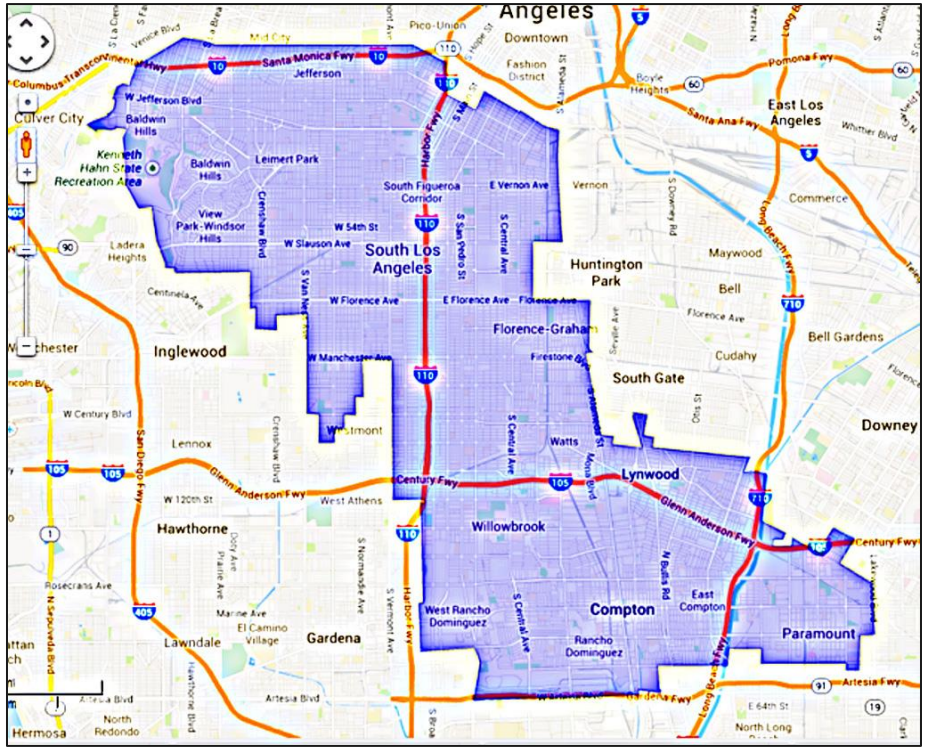
December 2020

Patient Story Depicting the Problem

Mr. M is working less due to COVID, running out of money for food and does not have transportation. He was recently severely injured in an accident with broken ribs, a collapsed lung and internal bleeding. Due to the pandemic and lack of hospital rooms in the region, Mr. M was discharged. Gabriela, care coordinator from St. John's Health Homes team was able to speak Mr. M at the time of his discharge, screen him for food and transportation needs and get him in for an appointment for the next day with transportation. He was connected to food resources during his medical visit.

Problem Statement

- In 2013, SJWCFC launched its Homeless Services Program to improve health, well-being, and housing stability through services provided at clinic sites and the Homeless Health mobile clinic. However, SJWCFC does not have experience, beyond CalFresh enrollment, in addressing food insecurity.



[1]http://publichealth.lacounty.gov/ha/docs/2015lachs/keyindicator/ph-kih_2017-sec%20updated.pdf

“To improve the health of the communities in South Los Angeles and Compton, health centers must address the behavioral, socio-economic and environmental factors that contribute to health. Food insecurity is a social determinant of health that should be accounted for in any population health strategy and care plan.”

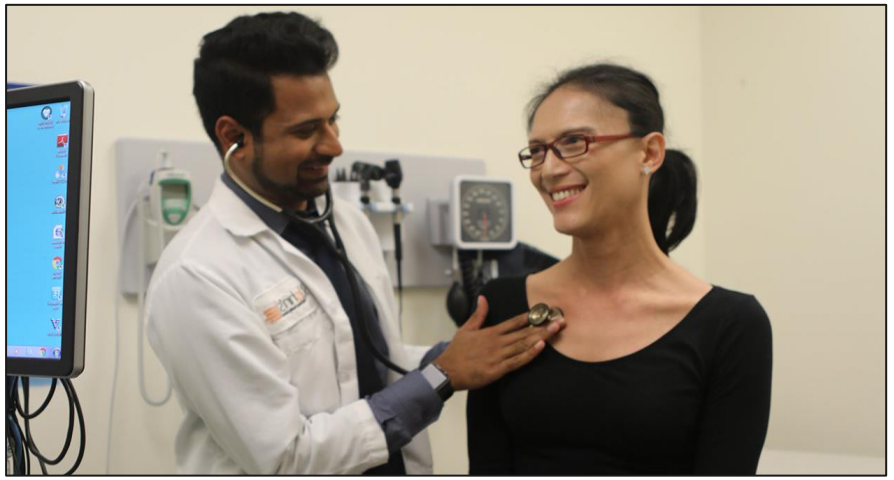
~ Elena Fernandez
Chief of Programs, SJWCFC

Project:

Increasing Food Access for High-Risk Patients in South LA

Increasing Food Access for High-Risk Patients in South LA

- Focusing on Homeless Health Services and TransHealth Program patients
- Using the PRAPARE and Hunger Vital Signs (HVS) screenings as SDOH screenings
- Connecting positively screened patients to local food resources
- Following up with patients through case management services



Exploring the Problem

Current Program

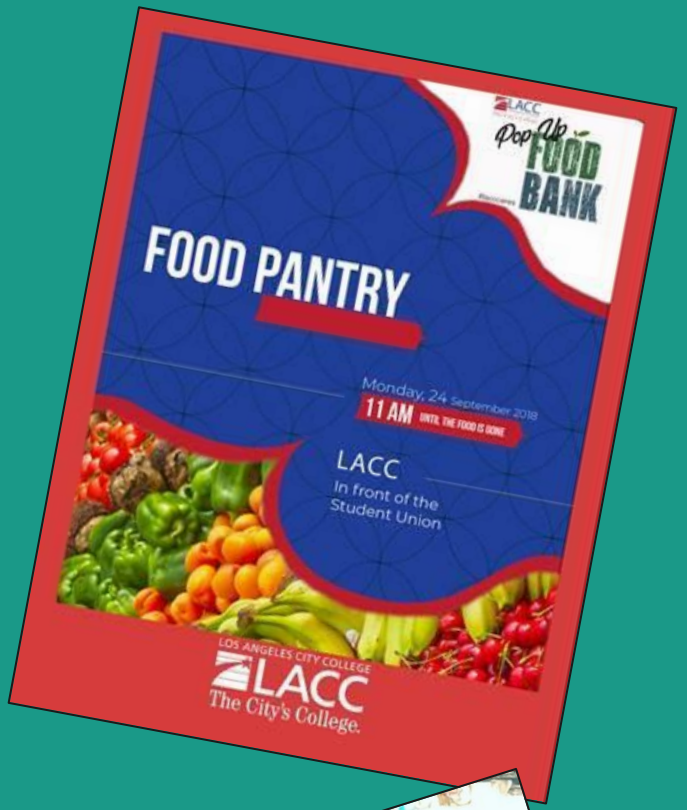
- Focusing on Homeless Health Services and TransHealth Program patients
- Using PRAPARE and Hunger Vital Signs (HVS) tools
- Connecting to local food resources
- Following up case management

Prior Approach

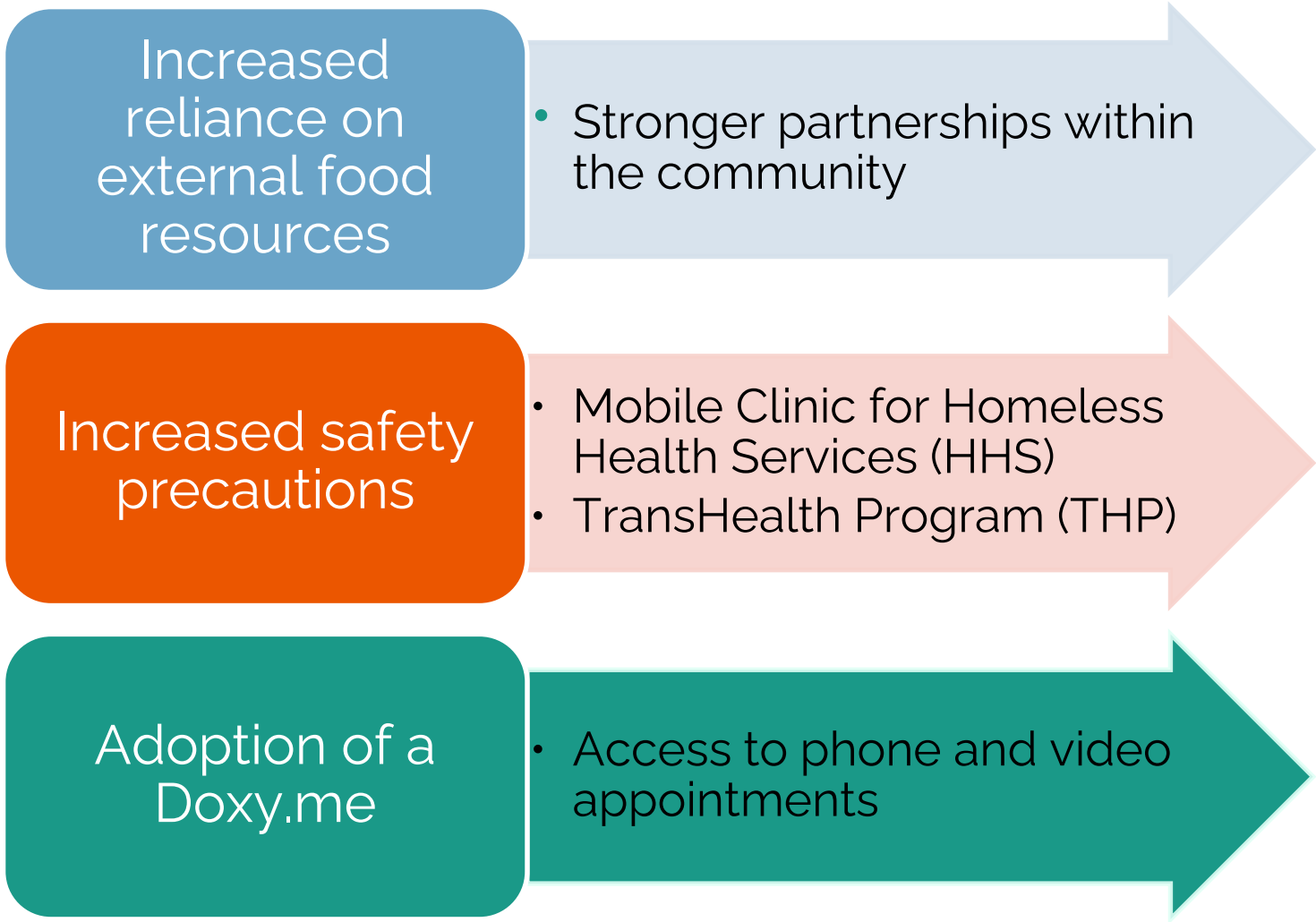
- Seasonal Food distribution: annual distribution of food for families to prepare for holiday dinners
- Case management staff would provide clients in highest need with gift cards to local supermarkets

Insights

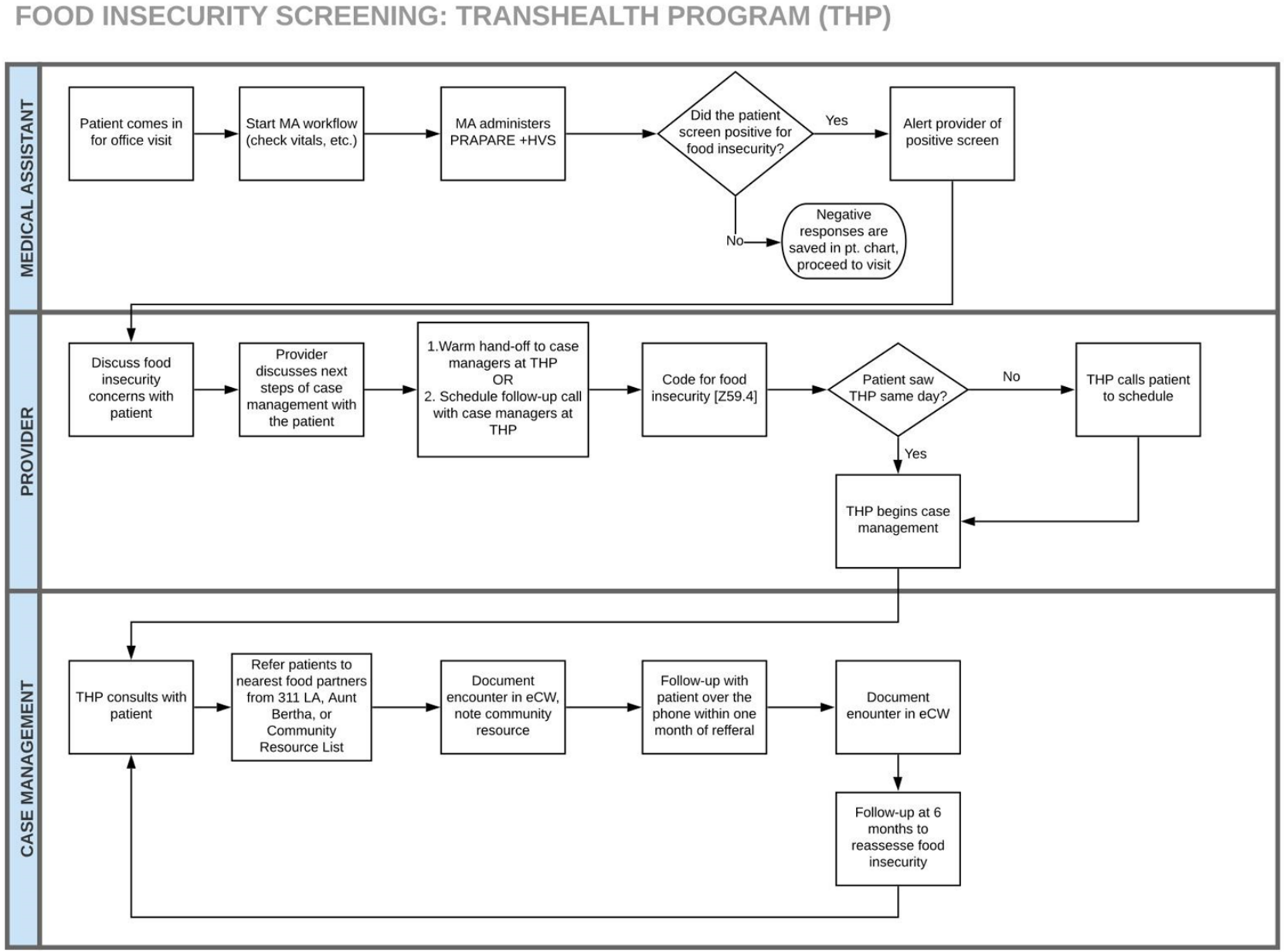
- Many patients already enrolled in CalFresh through other agencies
- Patients valued the pop-up food banks at partnering sites such as LATTC for direct access to fresh food
- Gift cards, referral to food banks and food pantries were a high need
- Investment needed to provide food resources (onsite food pantry)



How We Pivoted



Screening Workflow



Community Partnerships

LOS ANGELES REGIONAL FOOD BANK

Fighting Hunger. Giving Hope.

MEMBER OF FEEDING AMERICA

PROJECT ANGEL FOOD

APAIT

A DIVISION OF SPECIAL SERVICE FOR GROUPS

THE VOICE OF TRANSLATIN@S

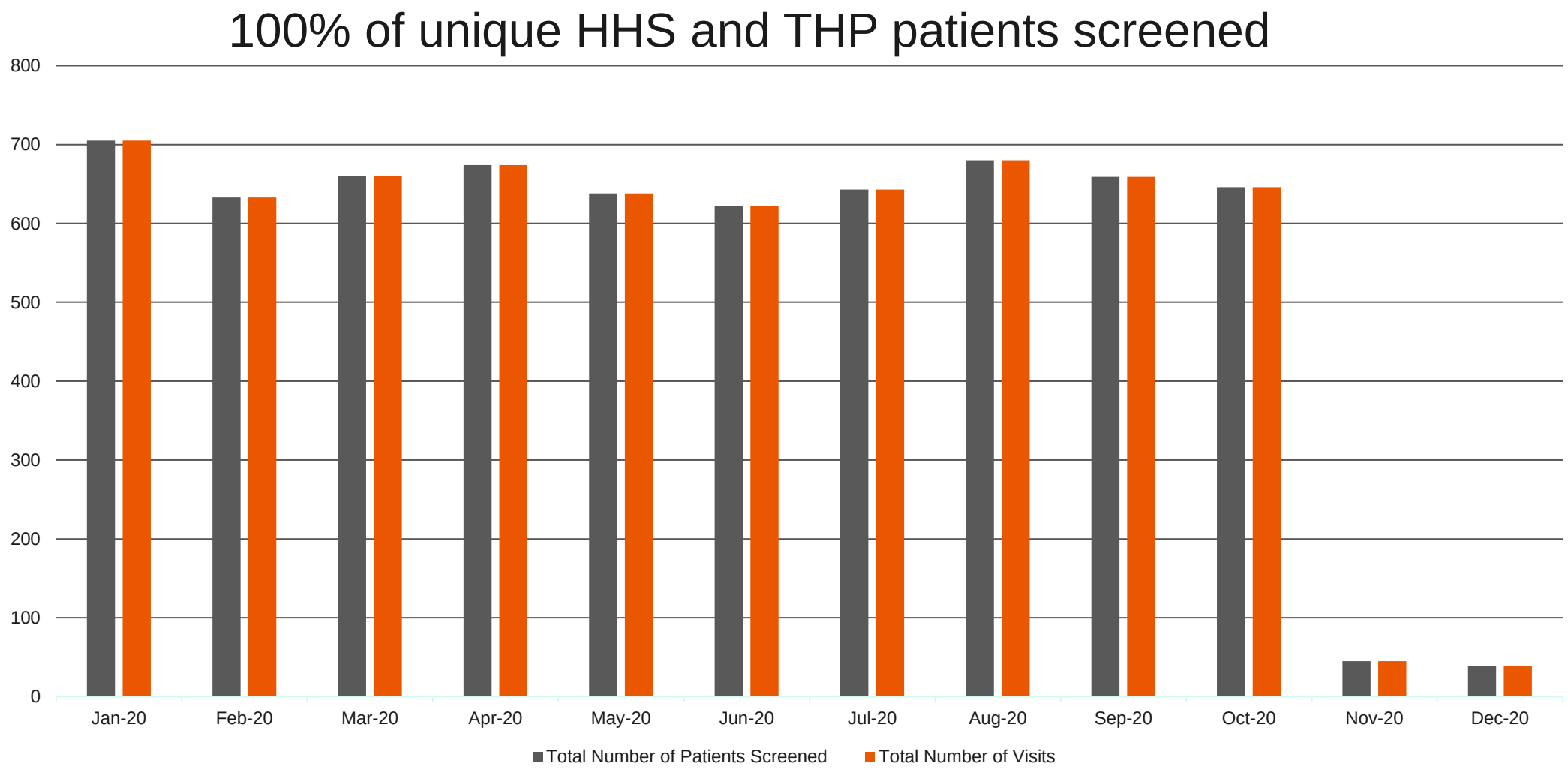
TransLatin@ COALITION

IN THE USA

MEALS on WHEELS AMERICA

TOGETHER, WE CAN DELIVER.

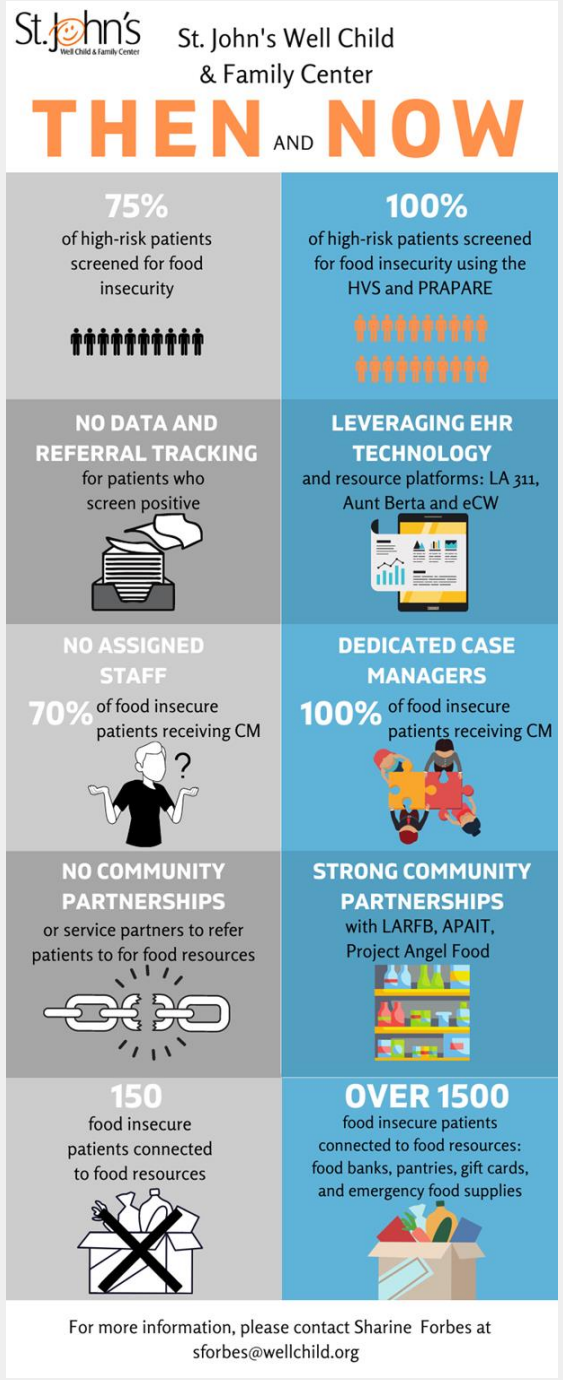
Impact Results to Date



During November and December staff were reallocated to COVID vaccination efforts, impacting data capture. Services continued.

THEN VS NOW

- 100% of food insecure patients screened using PRAPARE and HVS
- Leveraging eCW and community resource platforms like LA 311 and Aunt Bertha
- 100% of food insecure patients are receiving case management
- Strengthening community partnerships with LARFB, APAIT, Project Angel Food
- Over 1500 patients connected to food resources



Tanya

59 years old
Westlake Neighborhood
THP Patient
SJWCFC Patient since 2017

"I have had those [food insecurity] issues. Sometimes I was pinching pennies, I had a lot of fixed income without security.

Basically, St. John's is like a second home, I had no problems or issues at all with getting whatever I needed.

From St. John's I received surprise gift cards, basically gift cards for emergency food supply. And each time, it was given to me right on time.

[Pre-Covid], the group, when you went in there, gave free meals. You know, that was wonderful. I do believe that St. John's carries around a family environment, this project being an example of that. And that I love."

Tina

- 52 years old
- Los Angeles
- SJWCFC Patient for 6 years
- Asthma, Major Depressive Disorder

“It means a lot because they have helped me get back on track since I was homeless. I was connected to medical and other services that I really needed. I’m thankful.

I would feel emotional [if this project stopped] and sad because I got close to my CM, and it would hurt me if she can’t help me anymore.

She does a lot for me and I thank GOD for having her help me get the apt and provide me the food.

The service was very helpful because I didn’t have enough for Christmas and I was worried. It came at the right time.”

“The feeling is invaluable, being able to have at hand resources that offer a solution to a problem no patient should face.

When a patient alerts me they are experiencing some form of food insecurity, it is nice to be able to offer snacks or small convenient meals from our emergency food pantry, versus just giving them a list of food banks or meal handouts. It is one thing to give them a resource versus offering an immediate solution.

This project has been great in magnifying a problem our patients have experienced and are more so experiencing during Covid.”

Nube

- Non-Binary, Indigneous
- THP-Victim Advocate
- SJWCFC Staff for 2 years
- Case manager and patient liaison

- Declined photo
- Michael
- Intensive Case Management Services (ICMS)
- Over 1 year at St. John's
- Homeless Health Care

"Giving the food to my client and seeing the relief on his face is one of the most rewarding feelings I could have. Knowing I really helped a person obtain food has been satisfying."

- Declined photo
- Gabriela S.
- New Hire
- Case Management

“I feel grateful that we were able to provide a donation of food to [my patient]. Mr. Montes recently has been working less due to COVID, and has been running out of money for food. The little things we can do for our patients make everyone happy.”

St. John's Intensive Case Management Services

"I really appreciate the Gift Cards, especially the way things are today. I really needed assistance. Without the Gift Cards at the time, I don't know what I would have did. So I thank you." -Demetrius, SJWFC Patient

"[I feel] GREAT! I have been working in the field for 25 years. Makes me feel very humble and I know how it is being out there." - Michael, ICMS

"I wouldn't be going to my doctor appointments [for Hepatitis C treatment] without the help. It feels like somebody cares, I'm in a better place for it." - SJWFC Patient

Benefits of Project

- Understanding the struggles of the community and prioritizing their needs
- Focus on case management to always connect patient to food resource
- Ability to provide additional extremely needed services to patients in need as an important step in rebuilding their lives

Consequences if you discontinue the project

- Patient's will not have access to food resources that is available to them
- Need of food insecurity will increase
- Patients that are in the most vulnerable and marginalized populations will face further struggles in accessing food resources

Next Steps

- Connect with a food bank to organize a monthly food bank service at SJWCFC
- Continue to form connections with food resources local to the clinic area or specifically targeting specific populations

Support Needed:

- Partnerships needed by grocery stores. Any food bags and / or gift cards that can be donated can be of assistance for our patients

Thank you!

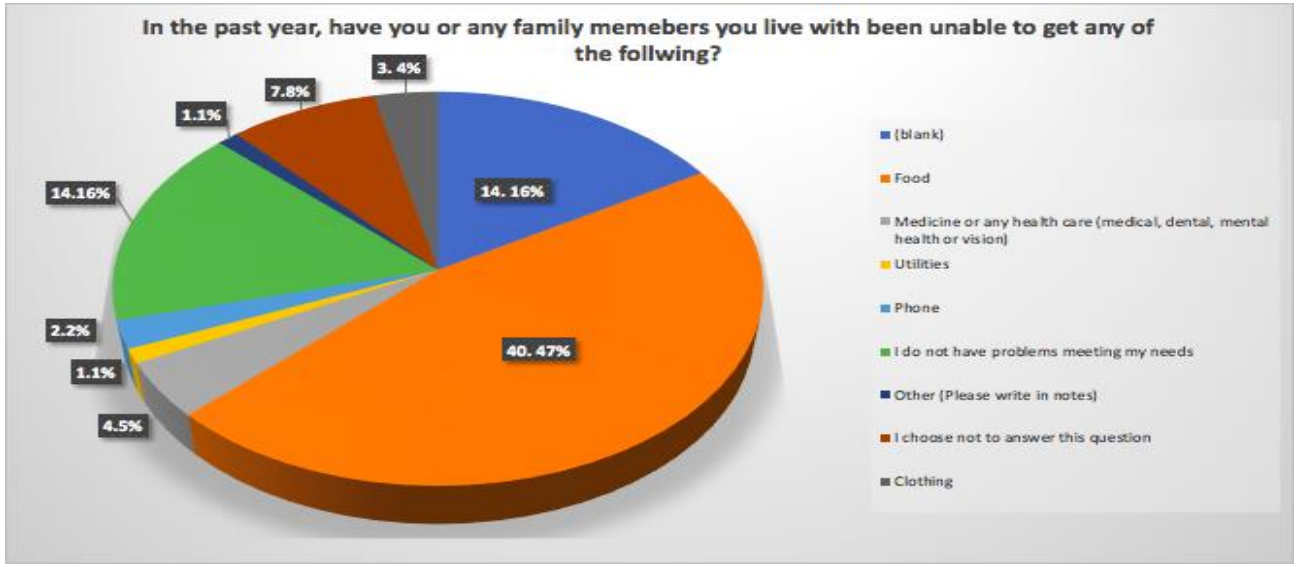
St. John's Well Child and Family Center

Monica Cotom, Elena Fernandez, Roberto Rodarte, Kazumi Yamaguchi, Sharine Forbes

If you have questions, please contact: Monica Cotom, mcotom@wellchild.org and / or Kazumi Yamaguchi, kyamaguchi@wellchild.org

Appendix

- PRAPAPRE FORM:



Hunger Vital Sign

Leveraging Transportation Solutions to Add

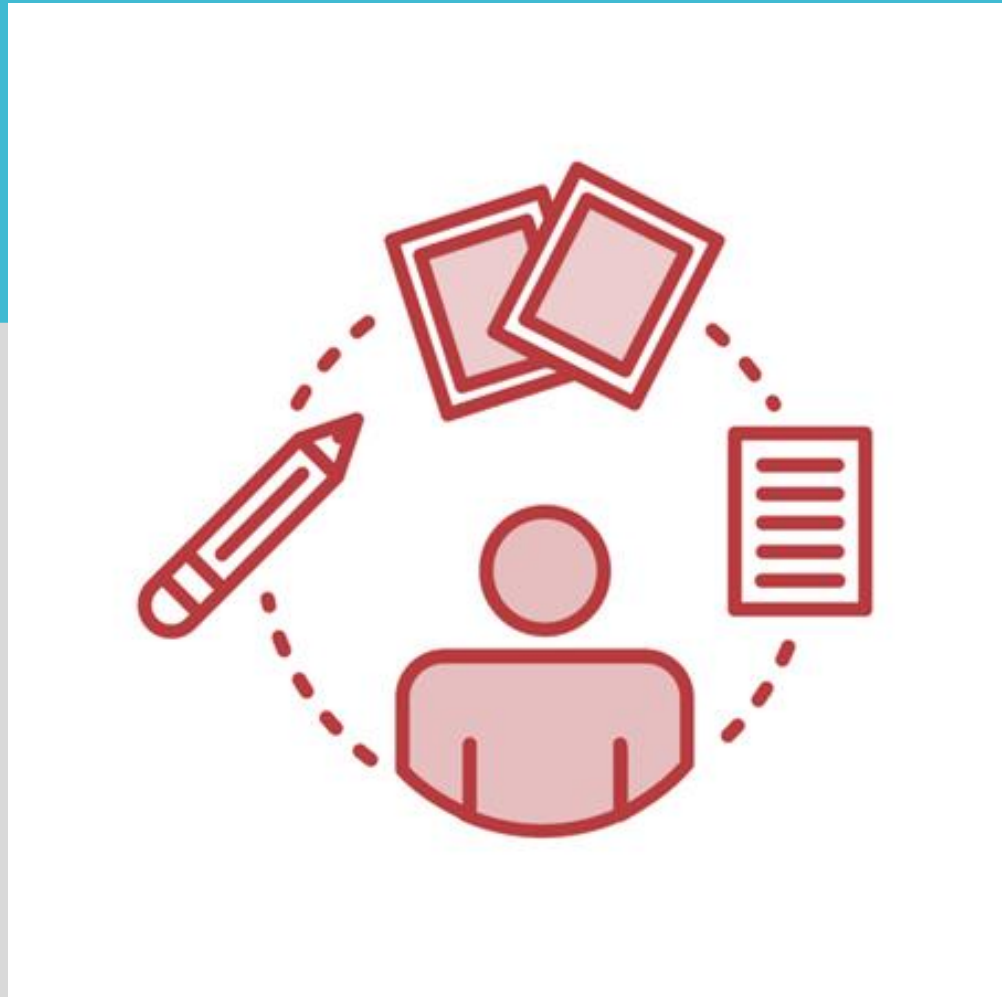
To Help Everyone Health and Wellness Centers
Cheryl Trinidad, Rosa Fernandez, Carmen Romero
Executive Leadership, Supervisors, Managers, Providers
December 2020

To Help Everyone Health and Wellness Centers

Founded 1974

Patient Story

- Mrs. G is 72 years old and diagnosed with _____, has difficulty navigating stairs and is vision impaired. Her condition requires her to come into the Crenshaw location multiple times per week and she relies on rides from family, friends and neighbors. She doesn't sleep well but is always up early and gets very tired by mid-afternoon. She prefers morning appointments. When she takes public transportation, she often waits about 20 minutes. A wait that she finds stressful and tiring. In the past two months she has rescheduled three appointments because her ride cancelled on her or asked her to changed plans.



Problem Statement

Shifting perspectives of leadership on importance and benefits of transportation services

Addressing the long-term SDoH needs of Patient

Not using the EHR or other software to track SDoH or transportation needs

Clinic van but no van driver had been hired

How We Explored the Problem

Previous Transportation Program

- Over 2,000 patients received rides through internal van service in 2017 (last full year of the service)
- Over 2,500 free bus tokens were provided through LA County MTA/FAME Assistance Corporation

Patient Anecdotal Evidence

- Patients expressed difficulty getting to/from appointments with provider and call center staff
- Explored fit of transportation solutions to specific needs (older adults, mothers with strollers, individuals with disabilities, mobility, vision impairment

Key Insights from Exploring the Problem

Patients appreciated and depended on van rides and bus tokens, although these programs were only offered for a limited time

Missed appointments were often due to lack of reliable transportation

Older adults depend on the van service (easier to navigate) and build a relationship with van driver and clinic staff

Capability of van to address needs of specific populations (family/ stroller friendly, access for older patients, those with mobility concerns)

Continuity of driver important: relationship with driver strengthens trust and clinic relationship (helps patients into the van, reliability and confidence to arrive at appt on time)

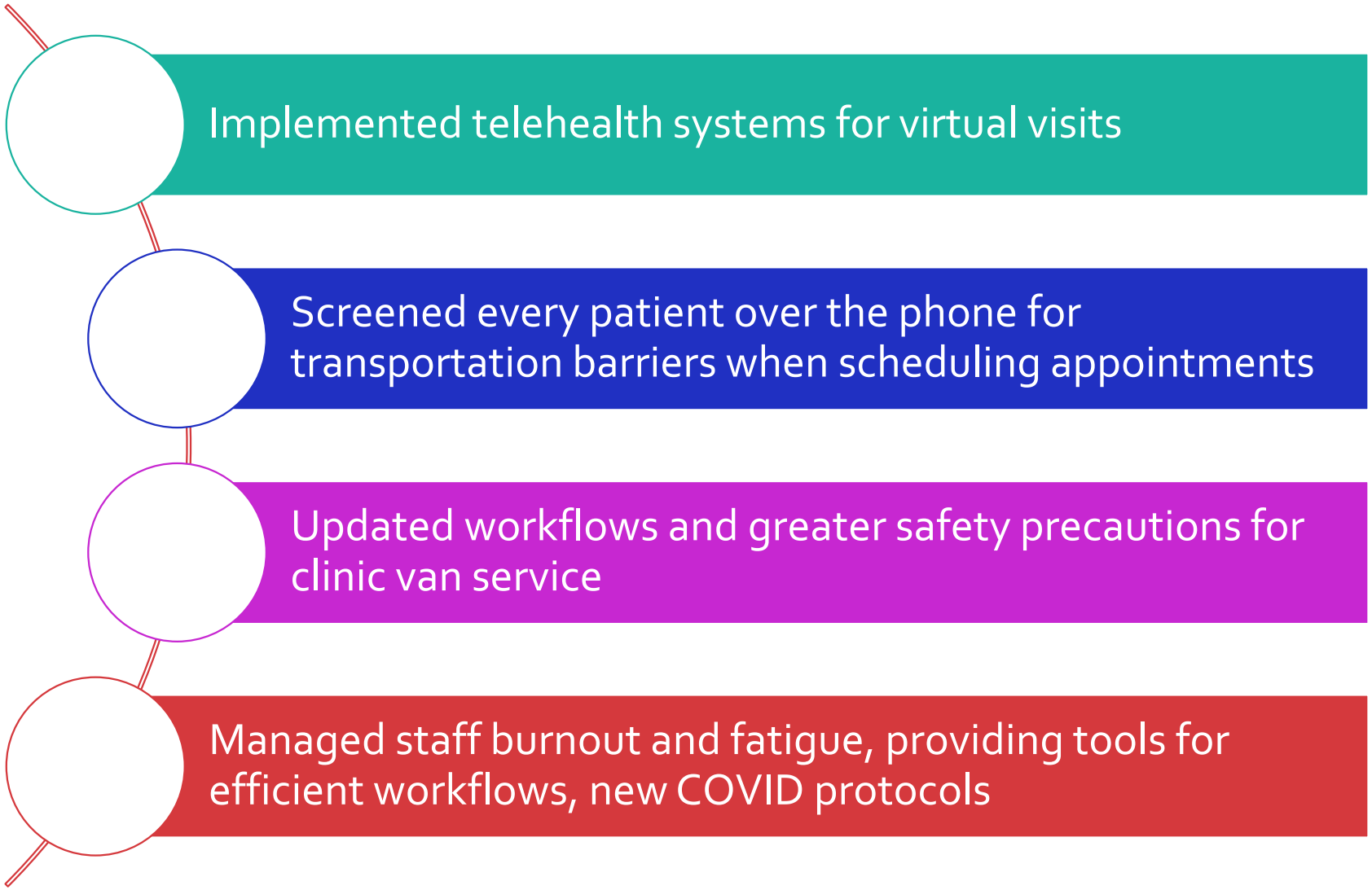
Value of standard and predictable workflow vs exception (reactive energy, uncertainty, blame, insufficient staffing). Ex. of prenatal visit with transportation arranged in advance

Continuity of service consistent with Patient Centered Medical Home (PCMH) and associated benefits to patient and clinic

> "Can Carmen pick me up?"

Leveraging Transportation Solutions to Address SDOH

How We Pivoted During the Pandemic



Leveraging Transportation Solutions to Address SDOH

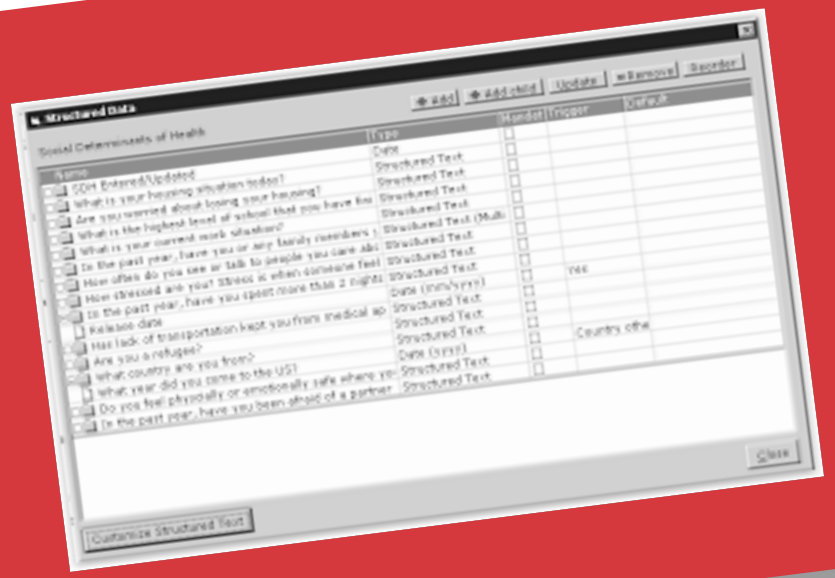
Readied existing clinic van to be put back into service

Call Center, Retention Teams and MAs screen patients for transportation needs at scheduling and during patient appointments

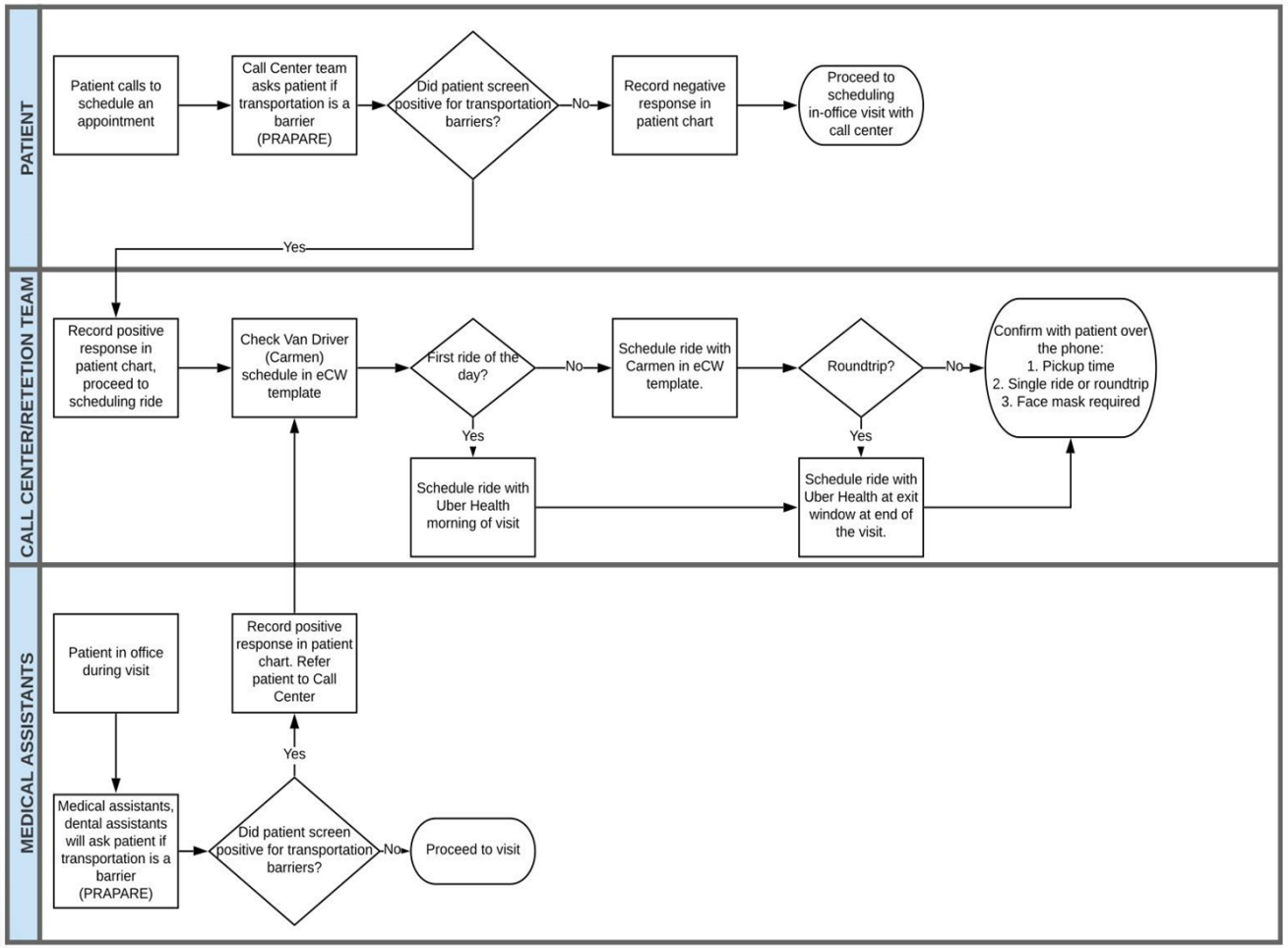
Retention team will connect patients to in-house transportation services through the clinic van or Uber Health

Patients are provided rides to and from their medical appointments

eCW Template & Workflow

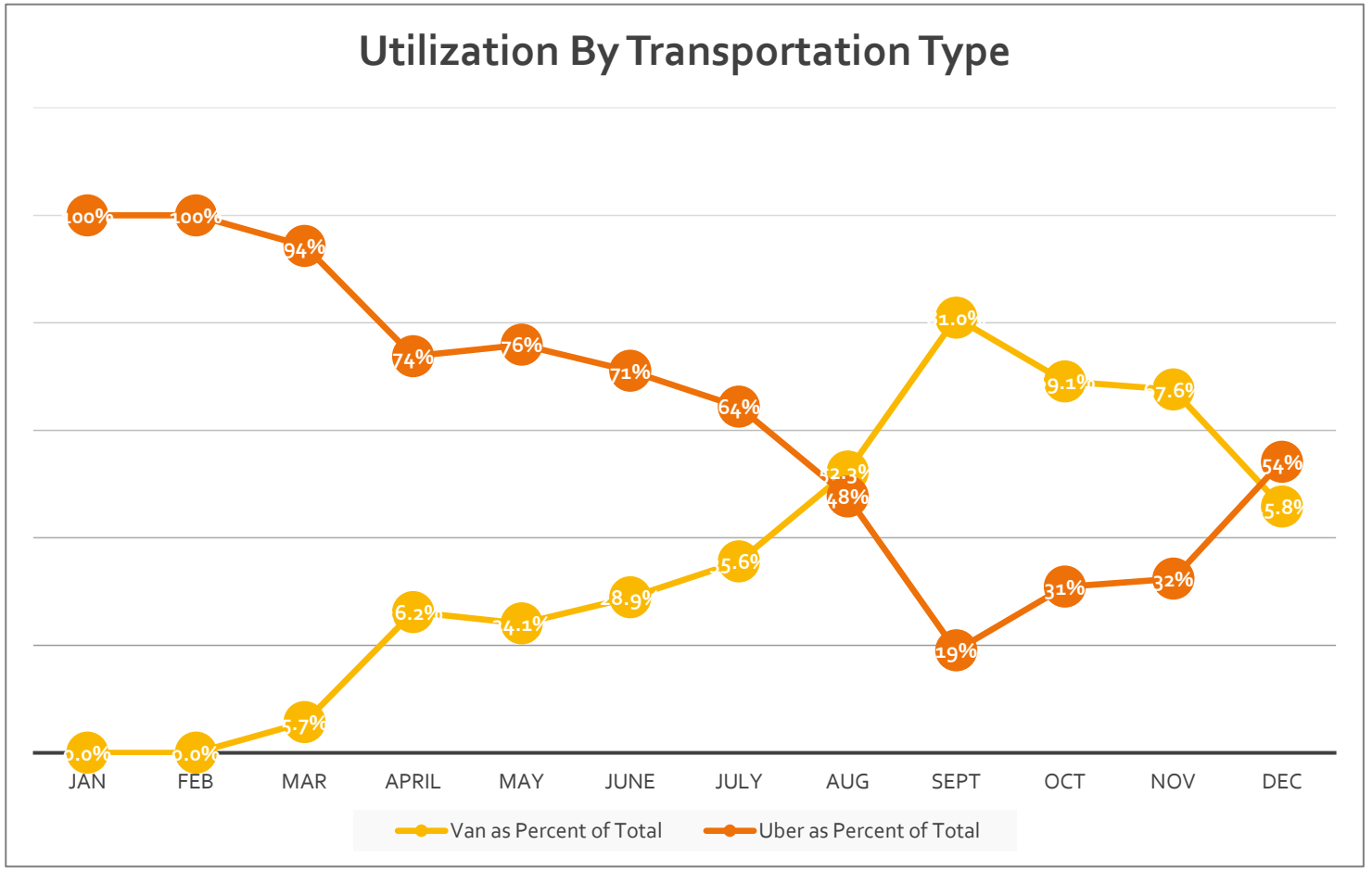


TRANSPORTATION WORKFLOW: ALL PATIENTS AT ALL LOCATIONS



Results to Date

- Van utilization averaged 36.4% of total transportation and steadily increased as implementation ramped up
- The average from April to December is 45.8%
- Peak use of the van was in September at 81% of total transportation
- Uber utilization increased in December when van driver was on vacation
- Stay at home order and virtual visits impacted data collection and complicated insights



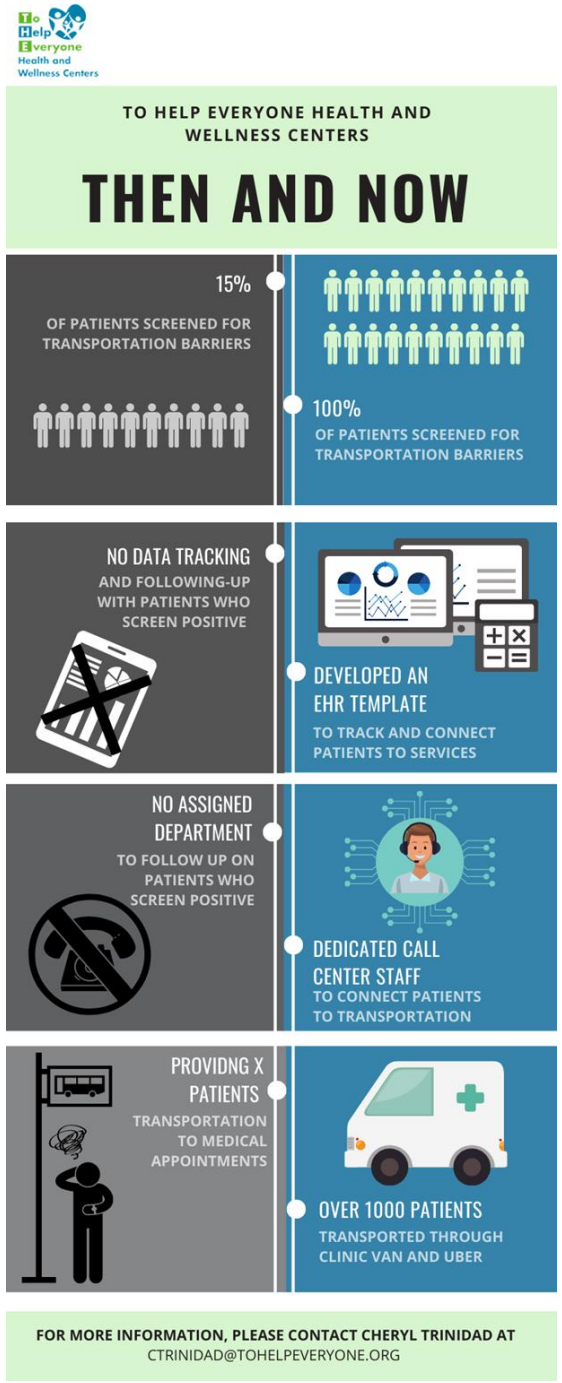
THEN VS NOW

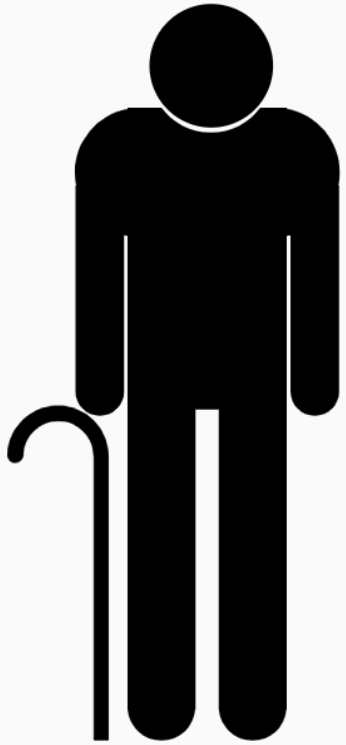
100% of patients are screened for transportation barriers

Developed a transportation template for outreach, scheduling, and tracking in eClinicalWorks

Dedicated Call Center and Retention Team to connect patients to transportation

Providing over 1000 patients rides through the clinic van and Uber Health





- 63 years old
- Primary care, older adult

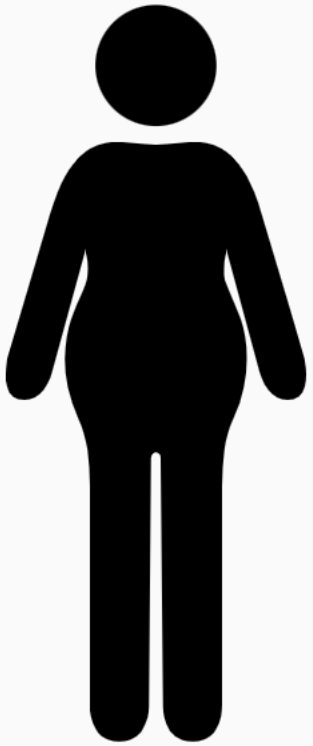
“It means a lot to be able to have these types of services to come to see my doctor.

I would be upset [if the project stopped]. I have no car or family members that have a vehicle to bring me. I feel my age plays a big part in being able to get places.

It’s very helpful and makes my appointments easier to attend. It also helps me plan out when I can make appointments to see my doctor.

Of course, I would love the service to continue, not only for myself but for other people that need it.

No impact [from COVID]. I love Carmen”



- 39 years old
- Prenatal care patient

“

It means everything to me! I specifically chose T.H.E. because of the transportation program. I do not drive and don’t have anyone to take me to my appointments.

It is easy to book appointments with transportation. The call center staff help me book my prenatal appointments and include transportation.

Older patients, parents with children that have no care, might also benefit from this service.

I feel safe with the driver (Carmen) [during COVID], and the van is clean.

”

- Carmen
- Clinic Van Driver
- 3 years at T.H.E., started as a patient service representative
- Provides patients transportation, patient engagement

"

It is much easier for patients to get to the clinic instead of Uber. Especially the older adult population, who are not technology savvy, it is much easier for them to schedule through the clinic.

Now especially with COVID, not everyone wants to use or feels comfortable using public transportation. I have a patient who suffers from back pain, so I will help her get in and out of the vehicle, and make sure that she feels comfortable during the drive. With Uber drivers, there is less control over the drivers and safety.

I feel really great! It makes me happy when new patients come to the clinic and find out about transportation services for the first time. It makes a big difference especially when patients have to travel to further clinic locations from their home.

Transportation services are doing really well currently. The connection/ communication between departments has definitely improved. The eCW template really helps for scheduling processes. I will scan through the template weekly and coordinate schedules accordingly so that patients can get to their appointments on time."

- Karla
- Retention Team
- 2.5 years at T.H.E (initially started at Call Center)
- Connects patients to transportation services

“

It is very fulfilling and important that we provide as many services that the patients need so the clinic can act as a one-stop shop.

It is great to have a transportation program so patients don’t have to worry about getting to their appointments, seeing other providers, or going to other locations because of transportation barriers.

I ask if transportation is a barrier when patients need to go to a clinic location that they are unfamiliar with. Patients will also let me know if transportation is a barrier, which shows that patients are comfortable with the health center staff.

“

Staff Perspective

"T.H.E. has come a long way"

Value of Our Project

The project demonstrated in very concrete ways, the value for patients and staff of having both a transportation program with a clinic van and uber that better meets the needs to patients

Shifting culture from an ad hoc "favor" for the patient to providing a value-added service with quantifiable impact

Value of participating in MCU – learned tips from peers (thank you Khier!)

Consequences if we discontinue the project

- Patients will not get to appointments at all, or on time and will struggle with transportation even when they do
- Staff will be disheartened knowing how needed transportation services are
- Retention in care and continuity of care will suffer

Project Next Steps

Our Ask for Specific Support

- By June 30, 2021 Confirmation/ blessing from CEO, CMO and HR to support more communication and training on the transportation services for all stakeholders including executive leadership, supervisors, managers and providers
- By June 30, 2021 Help from HR, managers, and QI Committee in clarifying authority for and empowering staff on who can arrange for patient transportation and setting expectations for accountability in arranging transportation when needed
- By April 30, 2021 Address consistent van needs. Facilities and HR to help with approval for designated parking spot for the van, Finance/CEO to approve gas card and budget for regular car wash for van

Thank you!

Cheryl Trinidad
Rosa Fernandez
Carmen Romero

Questions?

Cheryl Trinidad
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To Help Everyone
Health and Wellness Centers
Founded 1974

Utilizing Technology to Address Food Insecurity

Eisner Health: Pediatric and Family Medical Center
Haik Janoian and Felix Dominguez
Leadership and Administrative Departments
December 2020

Patient Story

- A single mother and two daughters, residents of South LA, and Eisner patients for 18 years
- Both daughters were asthmatic patients participating in Asthma Clinic when the mother was diagnosed with breast cancer in 2018
- The family was low-income, and the mother became unemployed shortly after her cancer diagnosis
- Pediatric Department and Case Management Team all pitched in personal funds and resources to support the family
- **Highlighted a need for greater investment in providing food resources and social services to patients**

Problem Statement

- Eisner patients and their families are disproportionately affected by social determinants of health, especially food insecurity
- Previous efforts to address food insecurity were difficult to sustain due to lack of infrastructure and funding
- The health center did not have standardized processes to screen for food insecurity, adequate technology to track data, or efficient referral pathways to follow-up on patients who screened positive

How We Explored the Problem

Previous Project Period

- Fruits and Vegetables Prescription Program with Target and Wholesome Wave
- Results showed a 38% decrease in patients reporting food insecurity
- Results could not be sustained due to lack of funding and staff capacity

Research on Tablets

- Talking Tablets used by various healthcare entities to electronically collect data
- Integration with EHR allowed data to be updated within patient charts
- Provided reading assistance for patients with low literacy levels with audio feature

Key Insights We Gained Exploring the Problem

- Leadership buy-in necessary to maintain staffing levels for sustainable program
- Tablet technology shows promise to increase efficiency and reduce staff time

The patient population I serve has many challenges that they face day to day and to be able to remove one can alleviate a huge amount of stress.”

-Luis, Director of Pediatrics

Our Project
Utilizing Technology to Address Food Insecurity

1.
Pilot talking tablets in one Pediatric clinic to capture SDoH data

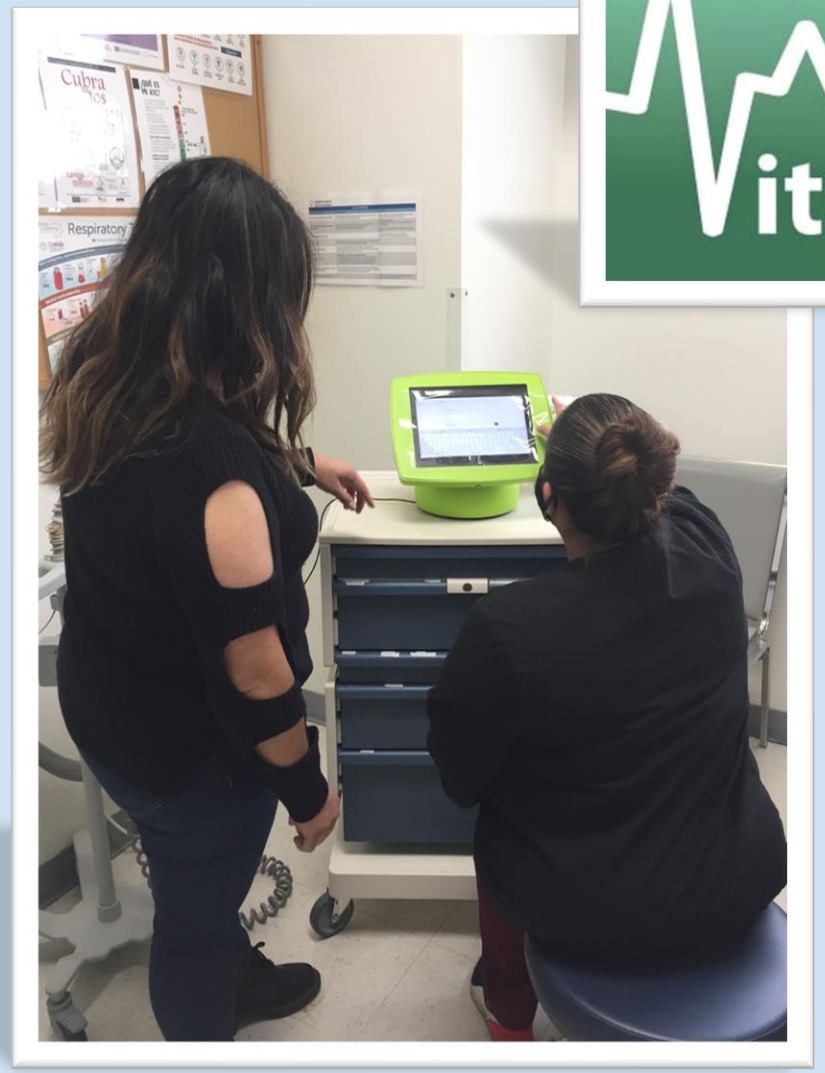
2.
Connect patients experiencing food insecurity with resources using One Degree solution

How We Pivoted During the Pandemic

- Screenings through tablets were placed on hold as less in-person visits and questions surrounding health safety
- Massive uptake in telehealth visits. Used Doxy.me to conduct virtual visits through audio and video
- Providers and MAs would screen for SDOH over virtual visits using questions in the EHR
- Saw a large increase in food insecure patients as COVID cases surged and people were out of work. Emphasized the need for more case management and reliable food resources

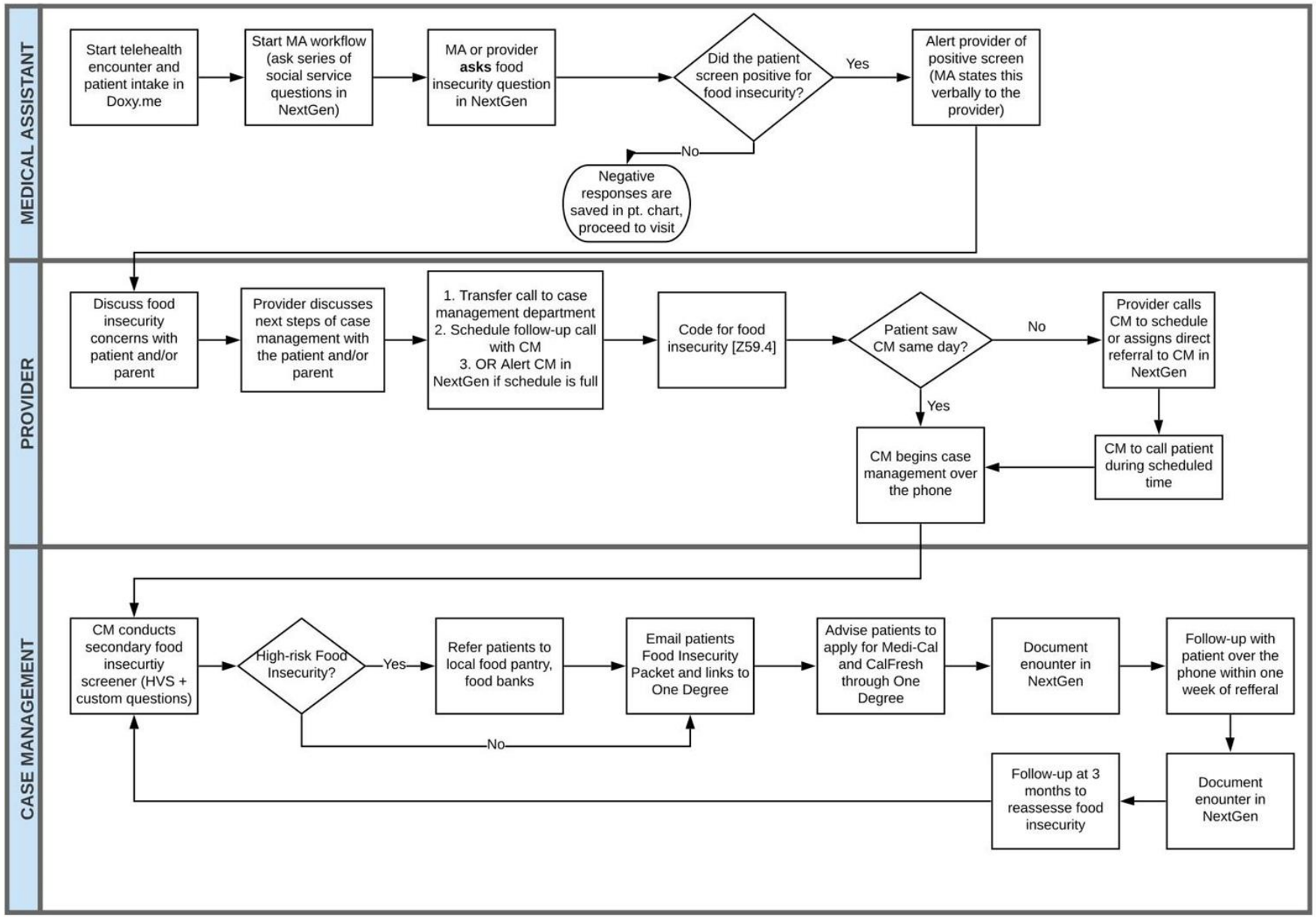
Utilizing Technology to Address Food Insecurity

- MAs screen pediatric patients for food insecurity using custom questions in the EHR
- Case managers follow-up on positive screens using the HVS and referral to resources
- Partnerships includes: LAUSD Grab N Go, Allies for Every Child, LARFB

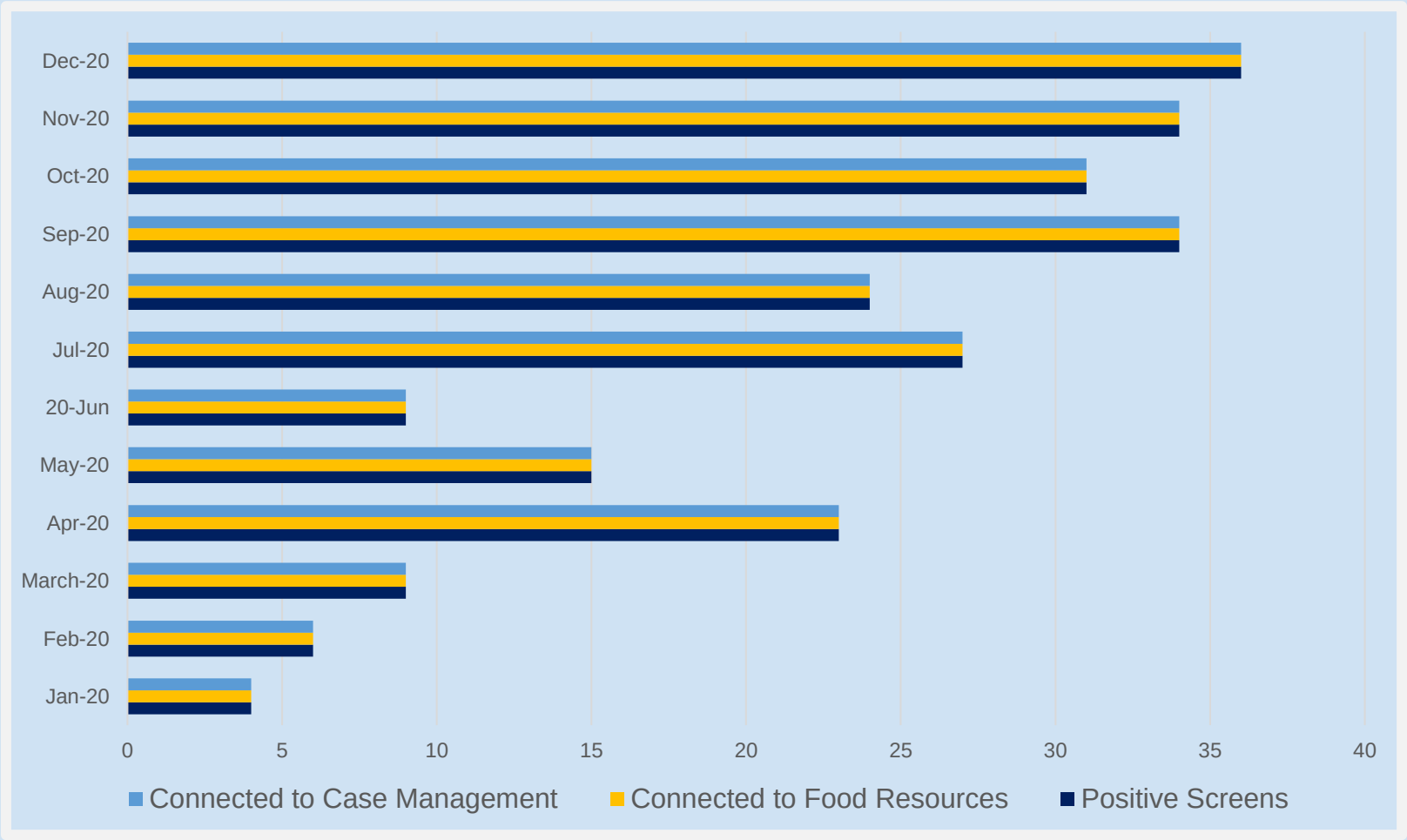


Partnerships

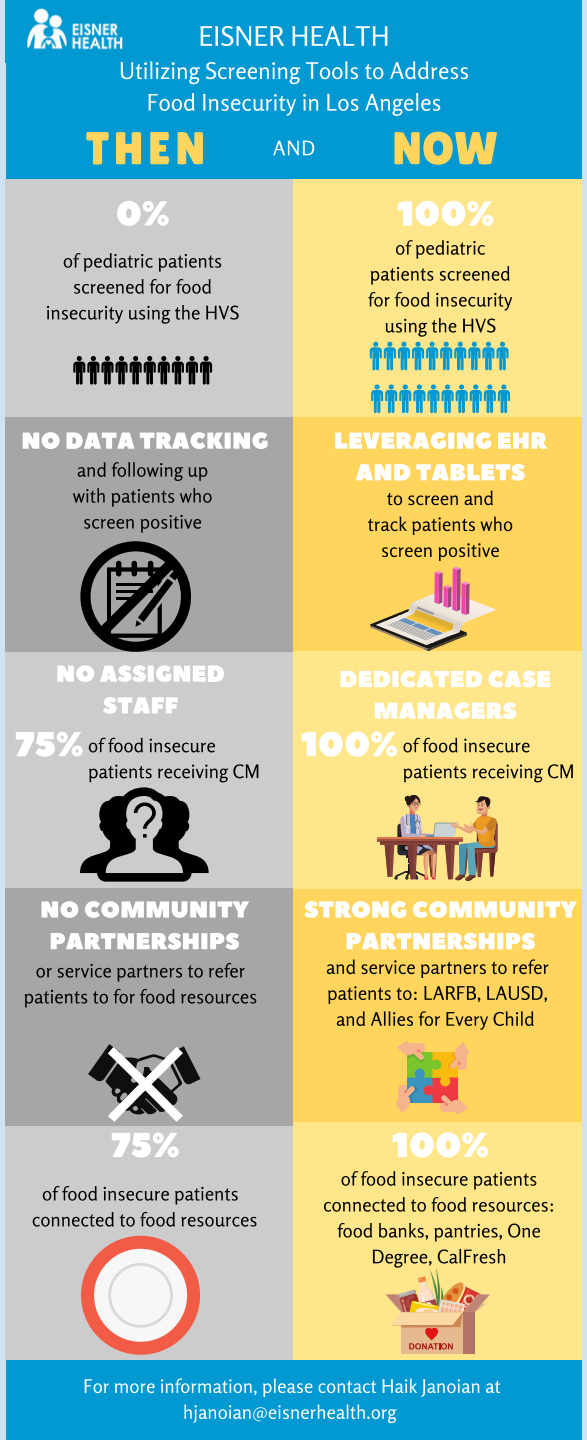
Telehealth Food Insecurity Screening: All Pediatric Patients



Results to Date

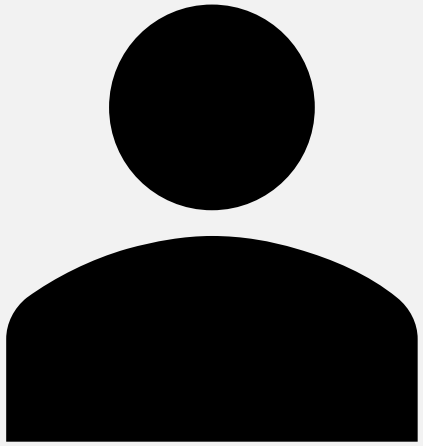


- Achieved standard work: connected 100% of positive screens to food resources AND case management
- Increased screenings over time with >30/ mo since September
- Work needed on capturing total screens and in office visits (denominator)



THEN VS NOW

- 100% of pediatric patients are screened for food insecurity
- Leveraging EHR and Data Tablets to screen and track patients
- Dedicated Case Managers to enroll patients into CalFresh and refer to resources using One Degree
- Strong partnerships with LARFB, LAUSD Grab N Go, Allies for Every Child
- 100% of food insecure pediatric patients are referred to food resources



Flor

39 years old

South LA

Eisner patient of 15 yrs

Asthma

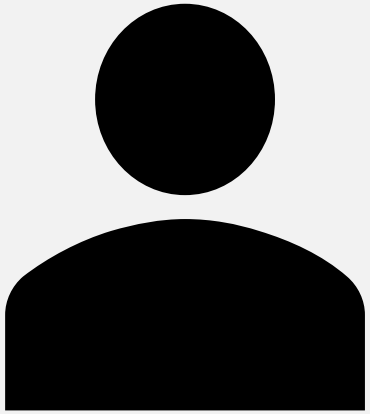
(declined photo)

"It means a lot to me and my kids that Eisner helps patients with food insecurity and Case Management, especially for me since I have been coming to the clinic for almost 15 years. I am familiar with the Providers and MAs who have been so supportive and kind to my children.

I have a sense of **confidence** where I do not feel embarrassed to ask for help when I need it. Also, it makes my life easier since I live close by the clinic where I don't have to drive far.

I would truly be disappointed and upset if Eisner would discontinue screening patients because I know that there are many families going through food insecurity like myself. Where else would they go? I know many families would not go elsewhere because they are fearful of **Public Charge**, fearful that it may affect their **Residency status**, and many have transportation issues. They can come locally to Eisner for help and resources.

The HVS Food Insecurity Screening was **very helpful** for me because I was able to find out about resources within my community and share them with friends and family that are going through a hard time with COVID. Even before **COVID**, times were tough for many of us in the community with lack of work and everything being so expensive."



Mirian

44 years old

South LA

Eisner patient of 22 yrs

Autisium, asthma

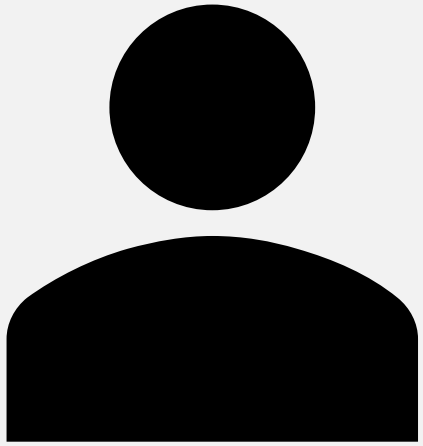
(declined photo)

"I feel very blessed that Eisner is screening for food insecurity and providing Case Management. Not being able to speak English and/or know resources, the Case Managers have made my life easier. Having **a family of 5** can be expensive and sometimes we run low on food at the end of the month, especially now due to COVID. The **kids are at home** more often now so that means more meals are needed daily.

It would be disastrous because I know many people in my community that are from other countries. They wouldn't know where to go or ask for help. Personally, going to Eisner for Case Management and resources was a blessing because I know that **I can trust them** and I honestly would know where to ask for help.

The screenings need to continue because poverty and hunger doesn't ever stop! The screenings helped me out tremendously during difficult times, especially now since my **husband's work hours have been cut** due to COVID and **I cannot work** because I have to tend my child with special needs. Money and food are not easy to come by.

I think they can improve the screenings if they were able to spread to other Departments other than Pediatrics and also if Eisner could develop a program where they can **distribute food at the clinic**. I know many families would feel more comfortable going to Eisner and not worry about **immigration issues** or feel embarrassed about asking for help."



Luis

Director of Pediatrics

27 years at Eisner

Provider Champion

(declined photo)

“I remember meeting with a patient prior to Thanksgiving where the patient’s mother was screened for food insecurity. During my encounter, the mother reported that her husband was recently deported out of the U.S.

The mother was **left alone with three children** to care for. The patient had multiple medical problems, mother had just lost her job, and they had no other family support. The mother did not want to tell me because of her **pride**, embarrassment, and she was scared because she thought it would result in a DCFS Report.

After her positive screening, Case Management was called for for support and Case Management located a local church that sponsored the entire family for the holidays. The church provided an entire Thanksgiving Dinner. In addition, the PEDS Department took a collection and provided an additional food basket and a grocery gift card.

The screenings have a tremendous positive impact on our patients. It assists Providers improve the quality of care we provide to our community and addresses a very ongoing issue that is common in most of my patients.

The patient population I serve has many challenges that they face day to day and to be able to remove one can alleviate a huge amount of **stress**. Also, it gives many patients a security that they are able to put food on the table and provide for their family.

I would definitely recommend that this project continue and **hopefully also be implemented into other departments and clinic sites**. Obviously due to the current COVID Pandemic, food insecurity has risen, but even prior and afterwards to the Pandemic, it is a very common issue in our community.”

Magali

- Case Manager
- 2 years at Eisner

From interacting with patients, some positive outcomes have been able to advocate to help those with language barriers understand information pertaining to them and resources. I have been able to provide support in food insecurities, housing, sanitation, and mental resources. Anything the patient needs, we try to help with and have a positive outcome.

If I were not providing case management, many patients would not be able to reach and know about resources available to them. This would negatively affect their health, overall well-being, and their right to make **an informed choice**. For example, I was able to become a liaison between a mother and her child's speech services. Prior to talking to her, she did not know that she had access to such services. Now the child is receiving these services that have improved his quality of life and education.

Being able to be a resource to more resources for a patient has brought me **joy** and satisfaction. Seeing them receive the proper care and services they need to live a better quality of life means that we're doing something with a **greater purpose**. Everyone deserves to be informed of resources that they need to lead healthier lives and meet basic needs.

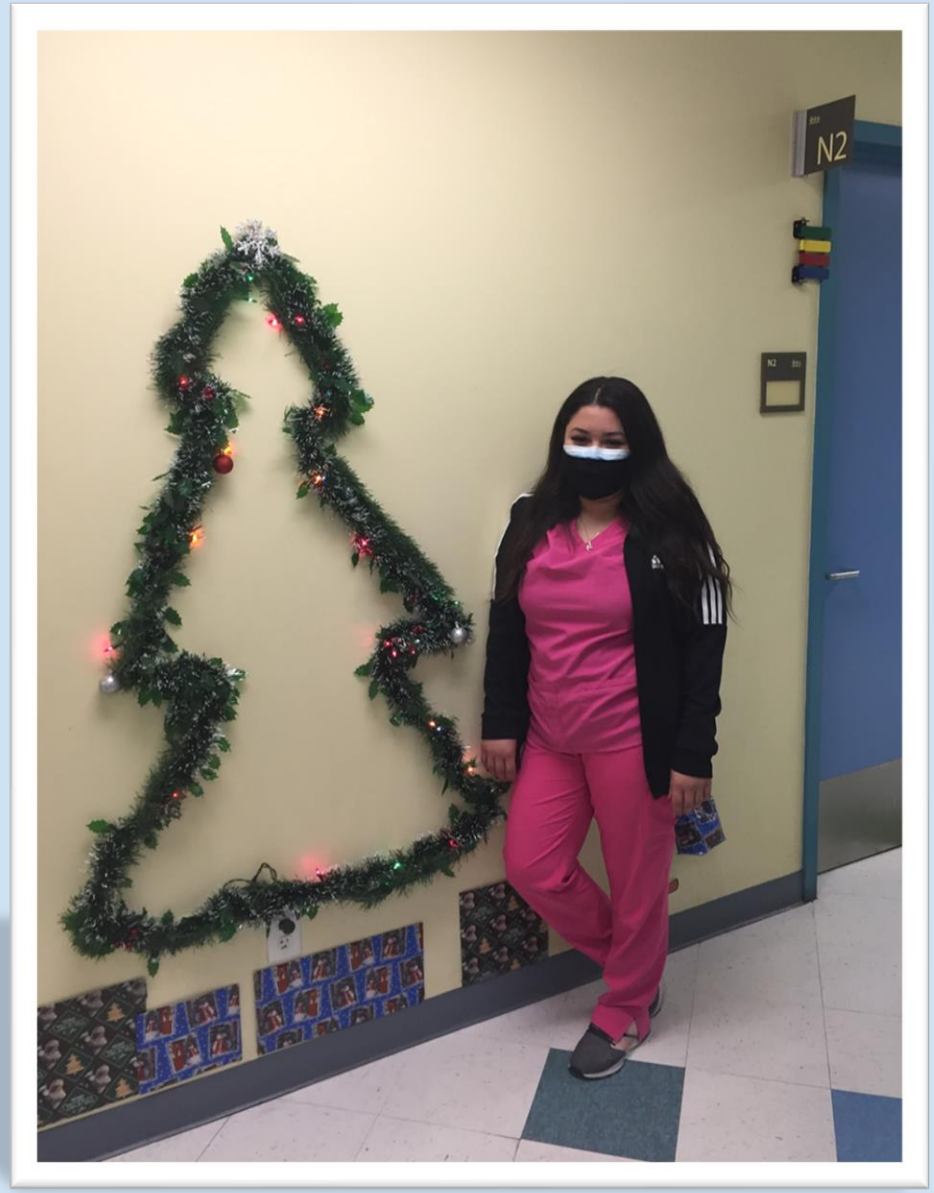
Food screening has great value because there's many people who are unaware that they have access to food resources like Los Angeles Regional Food Bank. Many of these families are of low-income households that may not know that there's important work in pediatrics as the nutrition of children is very crucial in their mental and physical development.

There's always room for improvement. Communication and helping parents voice their concerns **regardless of legal status** is very important to build upon. Now knowing what they know, parents can feel more comfortable coming to the clinic and asking for resources and further information."

“I believe this program was able to provide the necessary sources to those in need due to many families losing their jobs.

The most valuable part is giving the patient and their families the security of knowing that they having the resources when facing hard times.”

- Bianca, Pediatric MA



“It is satisfying knowing our community is reaching out and we can provide help during hard times. It gives patients a sense of comfort knowing there is help and resources available to them during hardship.

The program should continue because many families who are in need can continue to benefit from this resources which can potentially help them get back on their feet when they most need it.”

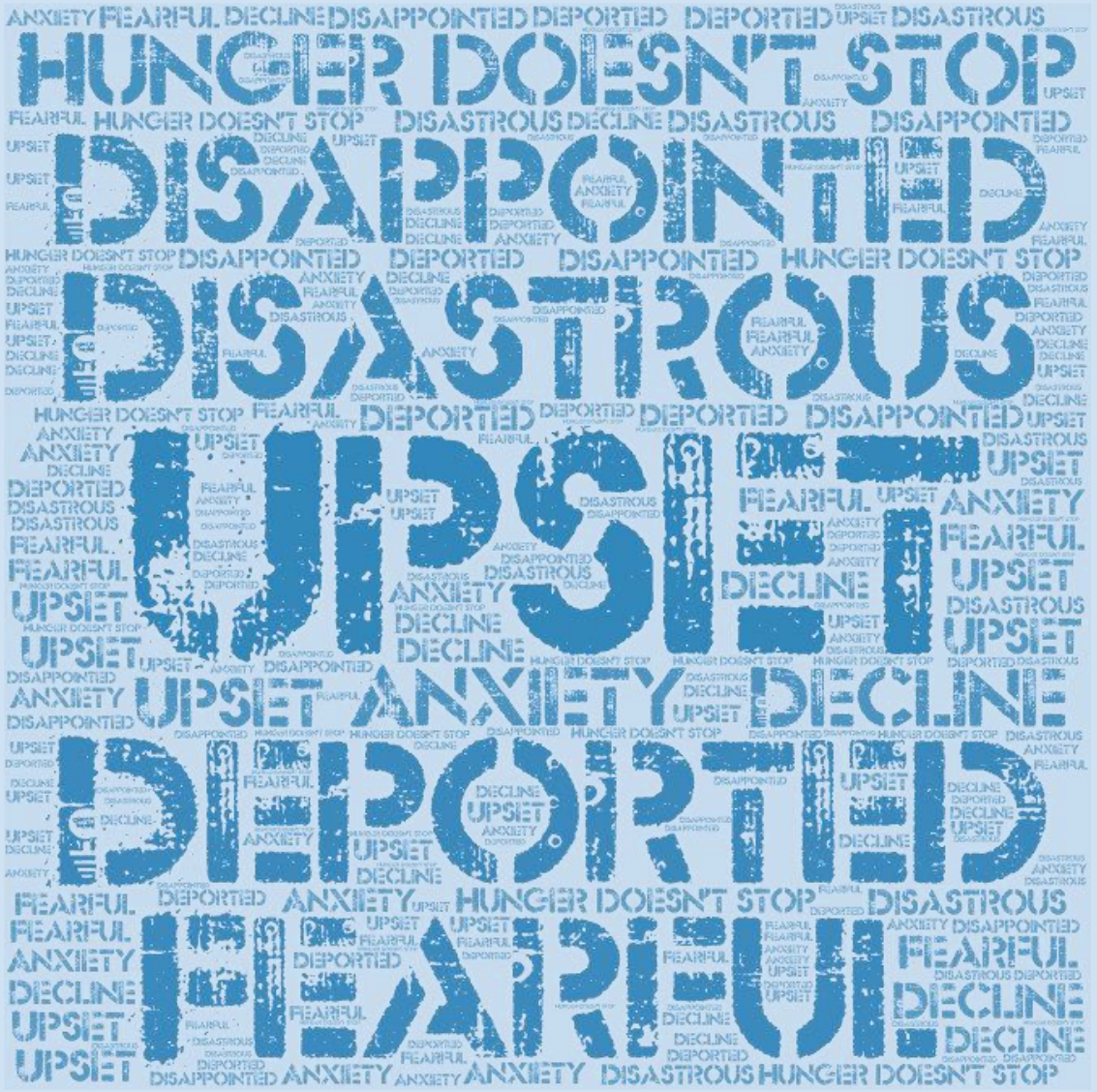
- Victoria, Pediatric MA

Project Value

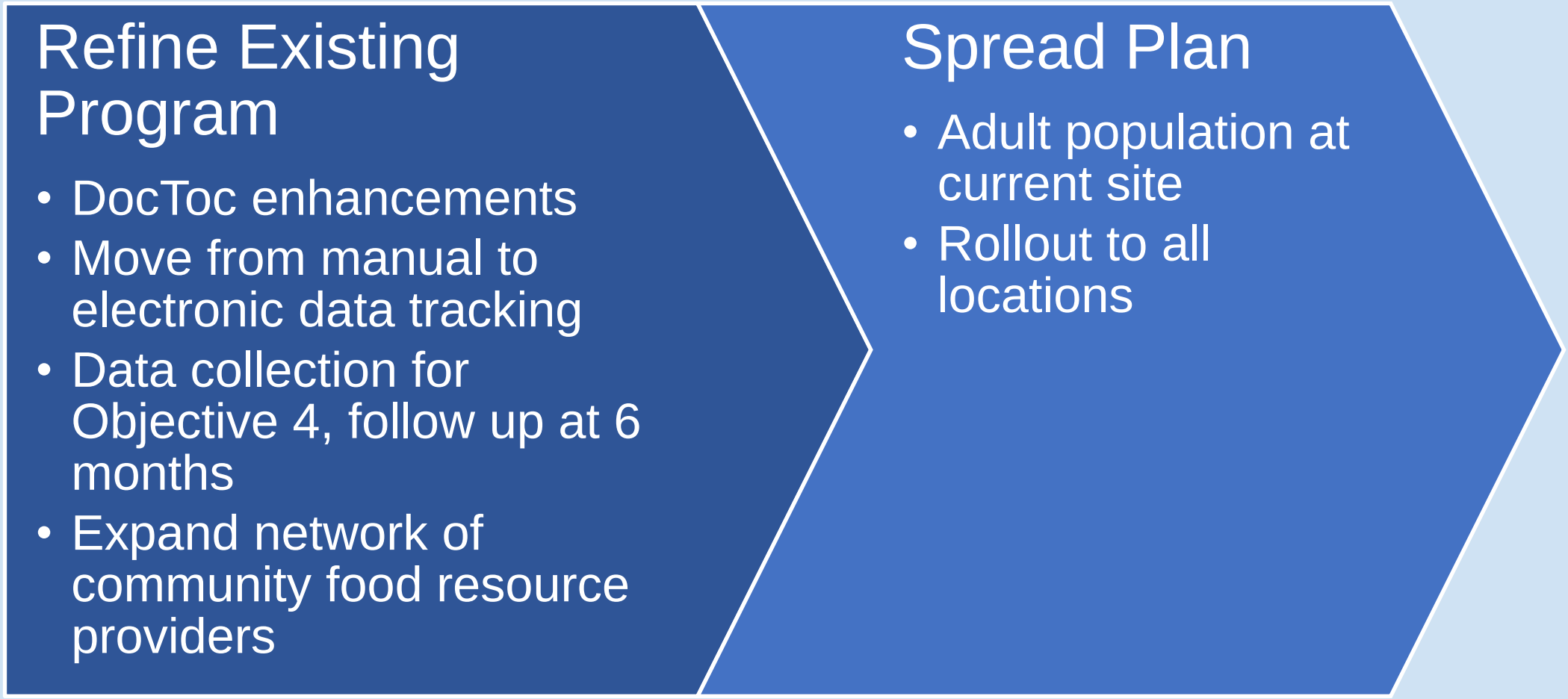
- Patients receiving services were surprised and very grateful to receive the help that they needed (were not aware services were available to them)
- Impact to COVID increased barriers and complexity in delivering services due to higher burden on limited staff, increase in housing and MH needs of patients (in addition to food insecurity)
- Consistent with Eisner's long-term objective to be the Health Home for each patient

Consequences if we discontinue the project

- Patients loose options for needed food supply, decline in over all health, possible increase in domestic violence, child abuse, other crimes
- Eisner would fall short in meeting its Health Home objective and may loose patients, decrease in patient continuity
- Staff may feel they are falling short in making a difference in a community they serve



Project Next Steps



Specific Support Needed at Eisner

In 2021, Leadership to commitment to fill open positions impacting project [project management, communications/ marketing, and nutritionist]

In 2021, Leadership and finance to approve budget for integration or interface of DocToc with NextGen, cost of $15,000 - $20,000 and Internal IT support

In 2021, Outreach to patients leveraging WellApp [vendor and internal IT support, Finance, Patient Education Department]

In 2021, Patient Education Dept to collaborate with project team to strengthen/ expand network of community food resource providers

Thank you!

Eisner Health:Pediatric and Family Medical Center

Haik Janoian and Felix Dominguez

If you have questions, contact: Haik Janoian, hjanoian@eisnerhealth.org